PATIENT REGISTRATION

Name: _____ Email Address: _____

Address: _____ City: _____
State: _____ Zip: _____ Home Phone# _____
Social Security # _____ Work Phone # _____
Birth date: _____ Cell Phone #_____
Married: ____ Single:____ Divorced:____ Wid:____ Male _____ Female _____
Occupation: _____ Employer: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name: _____ Relation to pt: _____
Address: _____ City: _____
State: _____ Zip: _____ Cell/Home Phone# _____
Occupation: _____ Employer: _____
Social Security # _____ Work Phone # _____

Do You Have Dental Insurance? Yes No
Insurance Company Name: _____ Employer: _____
Subscriber: _____ Subscriber's Social Security # _____Birth date:_____

GETTING TO KNOW YOU

Is another family member or relative a patient at our office? Y N
His/Her name:_____
How were you referred to our office? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name: _____ Best Phone # _____ Relationship_____

GENERAL CONSENT (which remains on file):

The undersigned hereby authorizes radiographs, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I also authorize any and all forms of needed treatment, medication and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I agree to assume full financial responsibility for Dental Services provided in this office for my dependants and myself. I understand that I am financially responsible for all costs of dental treatment, including any charges not covered or paid for by my insurance company, or any additional dentistry that may be necessary during this course of treatment. I also understand that my insurance company does not pay for all costs of dental treatment, and that our office cannot guarantee payment by my insurance carrier. I further understand that a 1 1/2 % charge (18% annually) will be added to any balance overdue by 60 days, insurance pending or otherwise. I also understand that unless I give 24 hrs. notice, I will be charged $50 per half-hour for an appointment that is not kept. I authorize release (including electronic) of any information relating to this treatment. I understand that the information will be sent either by mail or in unencrypted electronic form and there is some risk that third parties might be able to access this data. I hereby assign payment of my insurance company benefits otherwise payable to me directly to John L. Little, D.D.S., P.A.

Patient_____ Witness_____ Date _____

Guardian_____

Dental History

Name_____ **Date**_____

1. When was your last dental appointment?_____

2. What was done?_____

3. Are you having any pain or discomfort?_____

4. Do you feel nervous or anxious regarding dental treatment? Yes No
   Are you interested in learning about nitrous oxide relaxation therapy? Yes No

5. Have you ever had a bad experience in a dental office? Yes No

6. Do you clench or grind your teeth? Yes No

7. Does your jaw ever click or hurt when chewing or opening? Yes No

8. Do you have old filings or dental work that you don't like looking at? Yes No

9. Is there anything about your teeth that you wish you could change? Yes No

10. If so, what would it be? _____

11. Are you interested in learning about:
    - Professional tooth whitening? Yes No
    - Tooth colored fillings? Yes No
    - Cosmetic Bonding/Veneers (to restore stained or chipped teeth) (to close spaces between teeth) Yes No

12. Are you interested in learning about:
    - Invisalign (a technique to straighten teeth without braces)? Yes No
    - Orthodontics(to straighten or close spaces between teeth)? Yes No

13. Are you interested in learning about Implants (to replace missing teeth, make dentures more stable) and/or eliminate dentures) Yes No

14. Please list other questions, concerns or comments that you have about your mouth and oral health._____

_____

Health History

Name_____

1. Physician's name_____ Phone Number_____

   Address _____

   Date of last physical_____

2. If you have you ever been hospitalized, please list the dates and reasons: _____
   _____

3. List all medications taken in the past two years (including vitamins, birth control and pain relievers):
   _____

4. Do you smoke? Yes__ No__ If yes, approximately how much per day_____

5. WOMEN: Are you pregnant? Yes___ No ___
   Are you nursing? Yes___ No ___

CIRCLE ANY OF THE FOLLOWING YOU HAVE EVER HAD:

alcoholism
anemia
angina
asthma
blood problem
cancer
chemotherapy
cold sores
congenital heart lesion
diabetes
dizziness/fainting
drug addiction
emphysema
excessive bleeding
glaucoma
heart murmur
heart problems
heart surgery
heart valve problem
hepatitis
herpes
high blood pressure
HIV/AIDS
joint replacement
kidney problem
liver problem
lung disease
mitral valve prolapse
osteoporosis
pacemaker
psychiatric treatment
radiation therapy
rheumatic fever
seizures
sinus problems
stomach problems
stroke
surgery_____
surgical pins/plates
thyroid problem
tuberculosis
ulcers
other_____

CIRCLE ANY OF THE FOLLOWING YOU HAVE EVER BEEN ALLERGIC TO OR REACTED ADVERSLY TO:

Aspirin
Amoxicillin
Antibiotics
Codeine
Erythromycin
Latex
Local Anesthetic
Nitrous Oxide
Penicillin
Tetracycline
Xylocaine/Lidocaine
Any other allergies_____

CIRCLE ANY OF THE FOLLOWING THAT APPLY:

Ankles swell during the day
Use more than two pillows to sleep
Chest pain on exertion
Slow healing ability
Special diet_____
Lost/gained more than 20 pounds in past year
Shortness of breath while walking
Wake from sleep with shortness of breath
Slow blood clotting

Please describe any disease, condition or medical problem not listed above:

_____

I certify that the above is correct to the best of my knowledge. I will not hold the dentists or their staff responsible for errors or omissions that I may have made in the completion of this form.

PATIENT_____ DENTIST SIG_____

GUARDIAN_____ DATE _____

JOHN L. LITTLE, D.D.S, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Updated Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information
We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national

security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.10 for each page, $25.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: John P. Little, D.M.D., J.D.

Telephone: 732-449-6564 Fax: 732-449-8606

E-mail: jlittle555@aol.com

Address: 804 Highway 71, Sea Girt, NJ 08750

DENTAL VISIT COVID INTRUCTIONS/CONSENT

Prior to Arrival

1. In order to protect you and our staff, please fill out and send us any forms we send you. We understand this process may be tedious, but the information is required by various government agencies for patient and staff protection.

2. If for some reason, you can't fill out a form, call us and we will verbally review the forms with you.

3. Patients must fill out a new COVID screening form prior to every visit. If the form indicates that you (your child) is at risk of having COVID, we will ask you to cancel your appointment.

Arrival

Please arrive 5 minutes prior to your scheduled visit. When you arrive for your visit, stay in your car and call our office for check-in instructions. You may be asked some health questions. (732) 449-6564.

Masks/Warm Clothes

Please wear a mask at all times except when the Dentist advises you to remove it. If you do not have a mask we will provide it at check-in. All office windows will be open, so please dress in layers or bring something to keep you warm if it is cold outside.

Guardians

There is a limit of one guardian for children under 18 or patients who need assistance. Guardians must wear masks and are asked to return to their cars while the patient is being treated. We will call you when the patient is finished.

Patients with Dental Insurance

Those patients who have been furloughed or lost employment will be fully responsible for verifying existing coverage. Our office will make every effort to help patients, however, lapses in coverage may not recorded by the insurance company until after a date of service. Patients are responsible for any dental fees not covered by insurance.

Hand hygiene protocol

Alcohol hand sanitizer is located throughout the office and patients are encouraged to use as needed.

CDC/OSHA/Government Infection Control

As in the past, our office meets or exceeds all infection control protocols to limit transmission of all diseases, including COVID-19 virus. We have also implemented many new protocols. Our staff is symptom-free, undergoes COVID screening every day, and, to the best of their knowledge, have not been exposed to the virus. Our protocols also include as much social distancing as practical.

Informed Consent for Dental Visit

Our office is committed to reduce the risks of disease transmission. Despite this, due to the nature of viruses, there is still a chance that you (your child) could be exposed to a virus in our office, just as you (your child) might be at another public place.

I understand and agree to the statements in this document; I also accept the risks and consent to dental treatment.

_____ _____

PATIENT/REPSONSIBLE PARTY **DATE**

COVID Advisory and Screening Form

Patient name _____

Our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus. Our staff is symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID 19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

FOR YOURSELF/CHILD PLEASE ANSWER " YES" OR " NO" TO THE FOLLOWING QUESTIONS:

TODAY AND IN THE PAST 14 DAYS--

DO YOU HAVE/HAD A FEVER?	**YES**	**NO**
DO YOU HAVE/HAD ANY SHORTNESS OF BREATH OR DIFFICULTIES BREATHING?	**YES**	**NO**
DO YOU HAVE/HAD A DRY COUGH OR SORE THROAT?	**YES**	**NO**
DO YOU HAVE/HAD FATIGUE OR STOMACH UPSET OT HEADACHE?	**YES**	**NO**
DO YOU HAVE/HAD LOSS OF TASTE OR SMELL?	**YES**	**NO**
WITHIN THE LAST 14 DAYS, BEEN AT A GATHERING OF 10 OR MORE PEOPLE?	**YES**	**NO**
HAVE YOU HAD COVID 19 or CLOSE CONTACT WITH ANYONE WHO HAS BEEN DIAGNOSED WITH COVID 19 OR SUSPECTED TO BE POSITIVE FOR COVID 19 ?	**YES**	**NO**
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED OUTSIDE MONMOUTH OR OCEAN COUNTIES?	**YES**	**NO**

IF SO, WHERE?

_____ _____

PATIENT/RESPONSIBLE PARTY **DATE**

_____

REVIEWED BY